SYNOPSIS

ON

AWARENESS, PERCEPTION AND IMPLEMENTATION CHALLENGES OF PRADHAN MANTRI MATRU VANDANA YOJANA IN HARYANA

For Registration

In

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Abbreviations

ANC	Ante-natal Checkup
CCT	Conditional Cash Transfer
CMB	Conditional Maternity Benefit
DBT	Direct Benefit Transfer
GOI	Government of India
ILO	International Labour Organization
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
MBS	Maternity Benefit Scheme
MCP	Mother Child Protection
MMR	Mother Mortality Ratio
MoHFW	Ministry of Health & Family Welfare
MWCD	Ministry of Women & Child Development
NFHS	National Family Health Survey
NHRM	National Rural Health Mission
PMMVY	Pradhan Mantri Matru Vandana Yojana
PW & LM	Pregnant Women & Lactating Mother
SDGs	Sustainable Development Goals
SRS	Sample Registration System
UN	United Nations
WHO	World Health Organization

1. INTRODUCTION

"Despite current programmes to improve the health of mothers and newborn babies, most recent figures show that one woman dies every minute due to pregnancy, childbirth or soon after giving childbirth."

- Daisy Mafubelu
Assistant Director-General, Family and Community Health, World Health Organization

Women as bearer and rearer of children form the foundation for bringing about the next generation of human resource for the economy. In order to breed good human resource, better nutrition for pregnant women & lactating mother (PW & LM) is essential. In the domain of health, maternal and child health issues still continue to be cutting edge of global and national health policies. Low birthweight has been a global issue and persistent efforts are made by prestigious organizations like United Nations International Children`s Emergency Fund (UNICEF) and World Health Organization (WHO) to alleviate the scenario. A newborn with weight less than 2.5 kilograms is considered in low birthweight category. Every seventh child is having low birthweight. Maternal health problem and maternal malnutrition are decisive factors for low birthweight. Babies born with weight lower than the cut-off (i.e. 2.5 kg) are prone to stunting, lower IQ, death in childhood. A good start in life begins in the womb. So, to grow a healthy baby, mother needs good nutrition, rest, clean environment and adequate antenatal care (UNICEF, 2019).

Acknowledging the aforementioned facts, almost every nation has a maternity benefit scheme for PW & LM. Being a developing nation with a huge population, under-nutrition is affecting the majority of Indian women. Every third woman is undernourished and every second woman is suffering from Anaemia. An undernourished mother almost inevitably gives birth to a low weight baby. Poor nutrition in utero affects the health of child throughout the life cycle since few of the changes are largely irreversible. Owing to economic and social distress, many women have to continue to work for earning a living for their family right up to the last days of their pregnancy. To curtail this situation, India too has a long history of maternity benefit programs with the objective of malnutrition free nation.

1.1 Evolution of Maternity Benefit Programs

The origin of maternity benefit schemes can be traced toward the last years of the 19th century in Germany when maternity allowance was made part of the insurance scheme. Great Britain made maternity allowances part of health insurance in 1912. Australia enacted the Maternity

Allowance Act in 1912. The ILO provides international recognition to maternity benefits through a set of conventions viz. convention nos. 3 in 1919, 103 in 1952 and 183 in 2002. Many developed countries like Sweden, Canada, Croatia, Denmark, USA, Kuwait, Colombia have good maternity benefits schemes with provision of maternity leave, paternity leave and/or family leave. Most of the countries have a provision of sharing the cost of maternity benefit amongst several organizations (Bala 2012, Rossin-Slater 2017, Attanasio et al 2005 & Lagarde 2014). CCT is the most innovative and effective approach in the domain of education and health, especially in developing countries (Schultz 2004). CCT programs are improving nutrition and health indicator by alleviating poverty among indigent households. One such famous CCT program that laid foundation for several schemes to uplift in education and health, is "Maxican Progresa Program" (Molyneux 2006, Maluccio & Flores 2005). Several Latin American countries introduced conditional cash transfer schemes modeled after Mexico's PROGRESA program. In Brazil, government sought to boost the maternity care by monthly cash transfers to PW & LM on committing to a "charter of responsibilities," that requires regular antenatal check-up for growth monitoring, and compliance with vaccination schedules (Morris et al 2004). Bangladesh have voucher program, known as "Demand Side Financing Program" in which vouchers comprising cash incentive, free access to antenatal, delivery and post-natal care etc. are provided to pregnant women (Nguyen et al 2012). In year 2005, Nepal introduced a nationwide Safe Delivery Incentive Program promoting institutional delivery through cash incentive (Powell-Jackson 2009).

Being a founder member of ILO, India has a long history of maternal and child care programs. There have been several legislations to provide maternity benefit in pre-independence era starting from Bombay Maternity Benefit Act, 1929 followed by other states like Madras, Uttar Pradesh, West Bengal and Assam (Chhachhi, 1998). After independence in 1947, GOI enacted several potent legislations for maternity protections starting from the Employee's State Insurance Act, 1948 followed by Maternity Benefit Act, 1961; Central Civil Services Rules, 1972 and Maternity Benefit (Amendment) Act, 2017. MBS are promoting financial inclusion, consequently, promoting the economic empowerment process (Singh 2014, Mokta 2014, Hasan & Parveen 2020). The maternity benefit programs in India can be grouped in four categories, as illustrated in Fig 1(Lingam & Yelamanchili 2011).

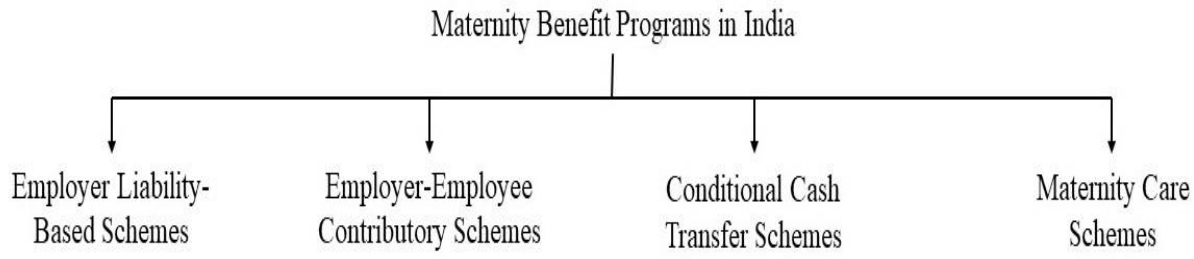

Fig. 1 Classification of Maternity Benefit Programs in India

Along with these maternity benefit legislations for organized sectors; GOI initiated several cash incentive schemes for potential beneficiaries of unorganized sectors. These programs have been innovative and accompany several revisions in due course after their implementation. The objective of all these cash incentive programs is to counter malnutrition and other maternal health related issues viz. MMR & IMR.

1.2 Employer Liability Based Schemes

The employer alone bears the full responsibility of providing maternity benefits to pregnant employees and the employees need not contribute anything for availing these benefits. After independence GOI enacted MB Act, 1961. The act provided employment protection to working women during the period of her maternity and entitles her maternity leave (ML) of 12 weeks. The act was applicable to all establishments of organised sectors having 10 or more persons (Swaminathan 2010). The act was amended as MB (Amendment) Act, 2017, making it more advantageous for the beneficiaries and more in line with ILO convention 183 as the ML are increased from 12 weeks to 26 weeks for two surviving children and 12 weeks ML are allowed for third children onwards. The provision of 12 weeks ML is also made for commissioning mother and adopting mother. For all establishments i.e. government as well as private sector, having more than 50 employees, the creche facility is also made mandatory (Bharathy 2018). In between, GOI came up with Central Civil Services Rules (CCSR), 1972, entitling all government employees, to avail 180 days paid ML for the first two surviving children and 45 days paid leave from 3rd child onwards. The provision of two years of child care leave during the service career was also made in the 6th central pay commission (Vinayan 2011).

1.3 Employer-Employee Contributory Schemes

Under this approach, the employees also share some liability toward employer in regards to provide service and maternity benefits. Employee State Insurance (ESI) Act, 1948 was acted

out under this approach. The act aims to attain the socio-economic justice enshrined in the Directive Principles of State Policy under part IV of the Indian Constitution. It covers varied benefits and the maternity benefit is one of them. It ensures a periodical payment to insured women in case of repression and miscarriage or sickness induced due to pregnancy. It outlaws the employer on dismissing and punishing employees during the pregnancy period when she has to avail leave. The ESI Act also covers organised private sector but the issues of unorganized sectors are yet to be addressed (Kumar et al 2018).

1.4 Conditional Cash Transfer Schemes

CCT programs are surging all around the world for boosting the education and health outcomes. The ESI Act 1948, the MB Act 2017 and the CCSR 1972 cover women employees working in organized sectors only. In the field of maternity care, CMB Programs are innovative to provide social assistance to poverty stricken and women working in unorganized sectors. Under this approach, various financial and non-financial benefits are provided to beneficiaries only on fulfilling certain conditions. All CMB schemes have been game changers in nutritional healthcare in India (Shah 2020). The National Maternity Benefit Scheme (NMBS) was introduced in 1995 as a part of the National Social Assistance Program under the ministry of rural development. Under this scheme, a cash incentive of ₹300 was given to pregnant women, who attained 19 years age and belonged to below poverty line family, for the first two live births. In 1998, the cash incentive was raised to ₹500 (Planning Commission. 2006). Later in the year 2005, the scheme was merged into newly implemented MBS namely Janani Suraksha Yojana (JSY) (Dongre & Kapur 2013). JSY is launched by Ministry of Health and Family Welfare under NRHM of the GOI, on 12th April 2005 with an objective of curtailing the maternal and neonatal mortality by encouraging institutional delivery among the poor pregnant women. JSY; translated as safe motherhood scheme, is the world's largest CMB program in term of the number of beneficiaries (MoHFW 2012).

JSY does not address the women's socio-economic compulsions to work right up to the last stage of pregnancy and resuming the work soon after the childbirth. To partly compensate the wage loss of PW & LM, a modest MBS was recommended in the XIth five-year plan. To meet this obligation, MWCD formulated the CMB scheme namely Indira Gandhi Matritva Sahyog Yojana (IGMSY; translated as Indira Gandhi Maternity Help Scheme). The scheme was put into action in October 2010 in most affected 53 districts in the country and a cash incentive of ₹4000 was given to mother of 19 years and above age for first two live birth. Money was

transferred to the mother's bank account in three instalments viz. ₹1500, ₹1500 & ₹1000 respectively, subject to the women effectuate specific conditions of maternal-child health and nutrition. All government/public sector undertakings' female employees or wives of employees are excluded from the scheme. In 2013, the IGMSY was brought under the National Food Security Act, 2013 and cash incentive was raised to ₹6000. The very purpose of the scheme was to improve the nutritional health of pregnant women and increase her weight as weight gained during pregnancy is a good indicator of their health **(**Coffey & Hathi 2016). In 2014, the GOI renamed the scheme as Matritva Sahyog Yojana (MSY); translated as motherhood supporting scheme (Hindustan Times Newspaper 25 May, 2017). On 31 December 2016, Prime Minister of India announced revamped the MSY and came up with **Pradhan Mantri Matru Vandana Yojana**; translated as Prime Minister Maternity Service Scheme. The rechristened maternity benefit scheme is implemented in the entire country in place of selected 53 districts (Prasad et al 2017). Maternal and infant healthcare have been corner stone of sustainable development and future generations. For reducing the maternal and infant mortality rate in line with SDG-3 targets, the maternity benefits cannot be restricted to hospital-based approach. The sustainable development goals reflect a new chapter conceptualizing the future needs of human race. Acknowledgement of diverse maternal healthcare needs can guide the nation toward achieving the goal of good health and well-being of all at all ages. PMMVY is framed with broader maternal healthcare perspective and for acknowledging the diversity of needs. According to NFHS data India is well moving towards achieving targets of SDG-3 with improvement in health seeking behaviour of Pregnant Women & Lactating Mother. The scheme is a part of GOI's initiatives to meet Sustainable Development Goals (SDGs) of UN by 2030 (PIB of 12 December 2019).

1.5 Maternity Care Schemes

These CMB schemes have some administrative obstacles in enrolling. Moreover, merely transferring cash does not necessarily mean that it will be used for its intended purpose. GOI has launched some alternative schemes to combat these drawbacks of CMB schemes and ensure maternity protection. The provision of free health checkup, nutritional supplements are provided to PW & LM. Janani Shishu Suraksha Karyakaram (JSSK); translated as Mother-infant safety program enacted on 1st June 2011 to supplements the cash assistance under JSY by offering varied entitlements to pregnant women at no cost viz. free transportation facility, free diagnostics, free drugs and consumables, free food with zero stay charges, free provision

of blood (MoHFW 2005). Another valuable maternity care scheme is Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA); translated as Prime Minister safe maternity scheme. It offers free, comprehensive and good quality ANC to every pregnant woman in her 2nd or 3rd trimester at designated PHC/DH by a physician or gynaecologist on 9th day of every month (MoHFW 2016). Universal Immunization Program (UIP) is another key intervention for protection of children from life threatening disease by providing vaccination (MoHFW 2016).

2. LITERATURE REVIEW

This section throws light on implementations challenges, utilizations, eligibility criterions, coverage and contribution of presently implemented maternity benefit schemes in India for poverty alleviation and health amelioration. For reviewing the existing literature on MBS, initially, relevant articles were identified by searching various database viz. Google Scholar, Scopus, PubMed, ResearchGate, Academia. The articles related to national maternity care programs were searched between the period from 1998 to June 2020.

Many researchers carried out surveys and came up with real facts. Assessment of the intervention coverage and health outcomes shows improvement in antenatal care and in-facility births and consequently, the perinatal, neonatal and maternal deaths are declined significantly. But an independent monitoring and evaluation system is needed for targeting the poorest and least educated women (Lim et al 2010). The education and socio-economic status of women affect the number of ANC visits and health care awareness. Educated people with sound socio-economic background are more aware about the health care and frequent ANC visits (Sharma et al 2012). One another study shows low utilization of JSY in the rural area as a high percentage of birth occurs at home as compared to that occurs in urban slums (Sharma et al 2011). People have a perception that free services are not of good quality, consequently, people with good socio-economic status in urban areas don't avail the JSY benefit and prefer private clinic. The women living in rural areas have better awareness (Kumar et al 2018). Moreover, the cash incentive under JSY is not significant to compensate for the maternity expenditure and need to be raised (Mukherjee & Singh 2018) and the delayed DBT to saving account is hampering effective utilization of financial aid for mother & child care (Malik et al 2013). These barriers affected the promotion of institutional delivery and the underutilization of existing ANC facility is also observed (Kumar et al 2019). But the women, enrolled under other

CCT or CMB scheme are encouraged to avail JSY package through intuitional delivery and vice-versa (Annual Report 2019-20 of Ministry of Women & Child Development).

PMMVY is presently implemented conditional Maternity Benefit (CMB) scheme to alleviate the out of pocket expenditure for pregnant women & lactating mother (PW & LM) (Krishnamoorthy et al 2020) and one of the key strategies to take a leap in sustainable development goals (SDGs) by conquering the maternal and infant health challenges (Vij & Singh 2020). Though cabinet approved the scheme on 19.5.2017, but it was brought into effect from 1st January, 2017. The implementation process of PMMVY involves various steps starting from identifying the potential beneficiaries and collecting the requisite information through AWW/ASHA, followed by online updation, verification using AADHAR credentials and payment through DBT. The key steps involved in beneficiary's application processing is demonstrated in Fig. 2(MWCD 2017).

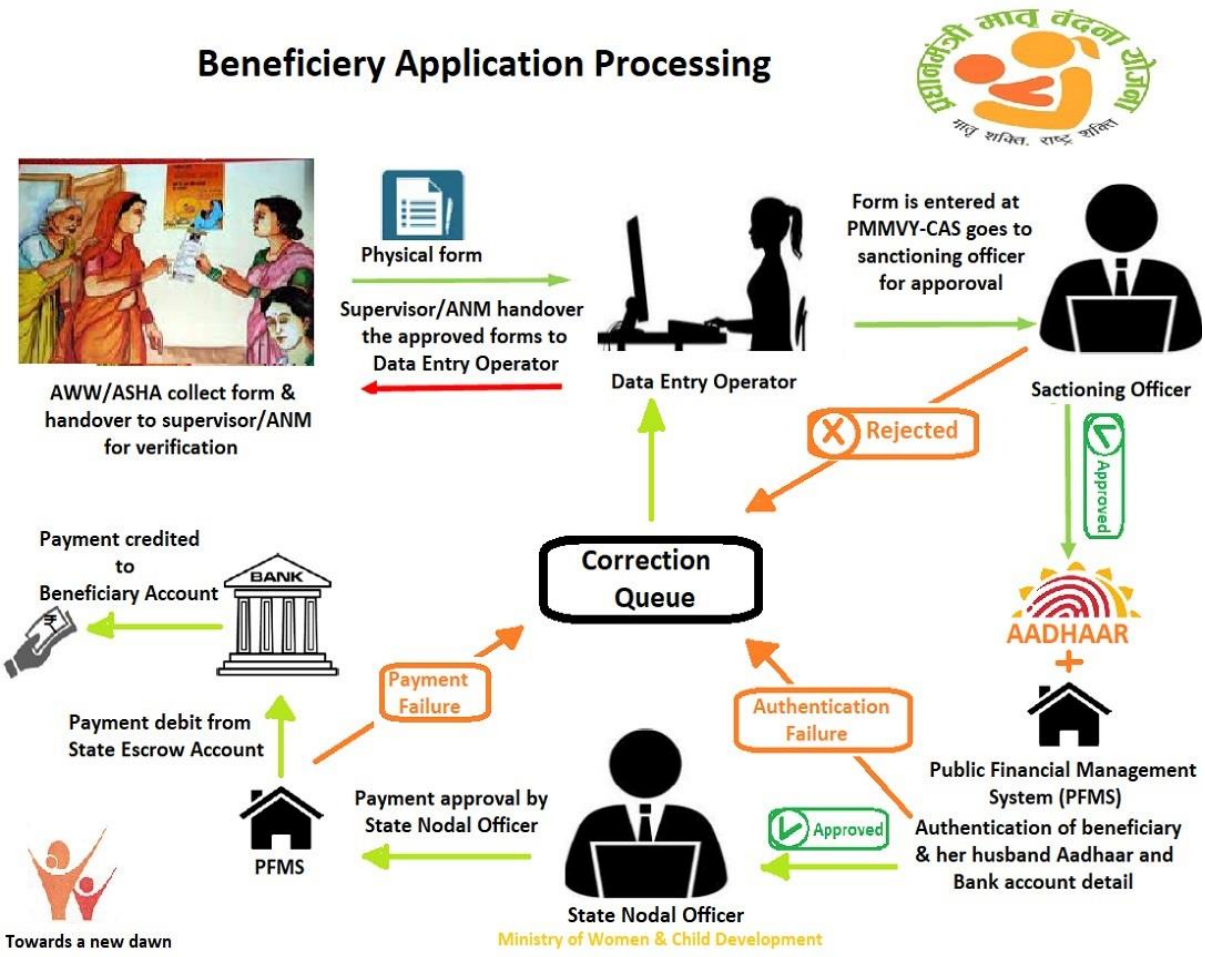
Beneficiery Application Processing
AWW/ASHA collect form & handover to supervisor/ANM for verification
Physical form
Supervisor/ANM handover the approved forms to Data Entry Operator
Data Entry Operator
Form is entered at PMMVY-CAS goes to sanctioning officer for apporoval
Sactioning Officer
Rejected
Approved
Correction Queue
AADHAAR
Public Financial Management System (PFMS)
Authentication of beneficiary & her husband Aadhaar and Bank account detail
Authentication Failure
Approved
State Nodal Officer
Ministry of Women & Child Development
Payment approval by State Nodal Officer
PFMS
Payment debit from State Escrow Account
Payment Failure
BANK
Payment credited to Beneficiary Account
Towards a new dawn

Fig.2 Steps of beneficiary application processing

The payment is directly credited to bank account of beneficiaries. DBT using Aadhaar has reduced the corruption drastically and improved transparency in CCT schemes (Bhardwaj & Cyphert 2020). To develop the health seeking behaviour among PW & LM; the payment is made in three instalments of ₹ 1000, ₹ 2000 and ₹2000 respectively. Three different application forms viz. 1A, 1B and 1C respectively, are required to fill for availing these three instalments. First two instalments are made before delivery to support the pregnant woman for ANC and having nutritious food along with partial compensation of wage loss. Third instalment is to meet the post-delivery expenditure and to allow the lactating mother to take adequate rest by partial compensation of her wage loss. It allows mother to breast feed the newborn and recover from weakness caused by pregnancy and delivery. The eligibility conditions and document required for the beneficiary are embodied in Table 1 (MWCD August 2017).

Table 1 Eligibility conditions and document required for the beneficiary under PMMVY

Instalment	**Amount (₹)**	**Conditions to fulfil**	**Document required**
1st	1000	➢ Mother requires to register her pregnancy in the MCP card within 150 days from Last menstruation period.	➢ Duly filled application form 1A ➢ Copy of the following: • Identity proof & MCP card • Bank/post office account passbook
2nd	2000	➢ Mother must have at least one ANC & can be claimed after 180 days of pregnancy.	➢ Duly filled application form 1B ➢ Copy of MCP card
3rd	2000	➢ Childbirth is registered & Aadhar card is issued ➢ Child has received the first cycle of immunizations of DPT, OPV, CG, & Hepatitis B.	➢ Duly filled application form 1C. ➢ Copy of the following: • MCP card & Child's Aadhar card • Child's birth registration certificate • Document of vaccination.

GOI sanction its share of grants to various state governments based on their requirement. The budget allocation of ₹2700.00 crore was made for financial year 2017-18. Financial sanctions of centre government for financial year 2017-18, 2018-19 and 2019-20 for all 36 states and UTs are illustrated in Table 2 (MWCD reports 2017-2020).

Table 2 Financial sanctions of Centre Government of India

Year / State/UTs	**2017** (till 31.12.2017) Amount (₹ in lakhs)	**2018-19** (From 1.1. 2018 to 31.3.2019) Amount (₹ in lakhs)	**2019** (From 1.4.2019 to 31.12.2019) Amount (₹ in lakhs)	**Total** Amount (₹ in lakhs)
Andaman & Nicobar	97.8	41.13	127.03	265.96
Andhra Pradesh	6520.38	14101.75	10125	30747.13
Arunachal Pradesh	612.18	36	0	648.18
Assam	9203.74	817	8098.18	18118.92
Bihar	16050.15	1570.23	0	17620.38
Chandigarh	271.22	248.08	343.01	862.31
Chhattisgarh	3938.58	2228.85	3272.12	9439.55
Dadra & Nagar Haveli	88.32	75.85	91.75	255.92
Daman & Diu	41.67	46.87	64.95	153.49
Delhi	0	921.06	2150.36	3071.42
Goa	149.92	113.19	140.13	403.24
Gujarat	9318.66	5958.97	8332.48	23610.11
Haryana	4085.3	3674.84	4936.8	12696.94
Himachal Pradesh	1587.6	1793.84	2379.51	5760.95
Jammu & Kashmir	2900.45	947.81	1807.26	5655.52
Jharkhand	5086.14	1453.37	3169.11	9708.62
Karnataka	9419.73	6361.72	8039.96	23821.41
Kerala	5150.58	3555.33	5348.96	14054.87
Lakshadweep	16.57	14.69	17.92	49.18
Madhya Pradesh	11197.67	18581.47	23786.41	53565.55
Maharashtra	11550.66	11795.62	21591.24	44937.52
Manipur	1263.42	209.65	411.51	1884.58
Meghalaya	875.05	102	278.95	1256
Mizoram	485.41	388.01	581.48	1454.9
Nagaland	875.31	52	171.81	1099.12
Odisha	6471.63	383	0	6854.63
Puducherry	320.68	96.74	119.88	537.3
Punjab	4277.49	1250.66	3553.68	9081.83
Rajasthan	10568.86	9605.43	9651.71	29826
Sikkim	270.12	21	87.99	379.11
Tamil Nadu	11123.7	658	2310.35	14092.05
Telangana	6520.38	661.02	0	7181.4
Tripura	1625.37	96	529.44	2250.81
Uttarakhand	2332.67	14216.71	2281.52	18830.9
Uttar Pradesh	31726.64	1425.66	34157.59	67309.89
West Bengal	9382.03	2938.72	8768.76	21089.51
Total	**185406.08**	**106442.27**	**166726.85**	**458575.2**

Source: Annual Reports of Ministry of Women and Child Development, GOI & PIB reports

The grant in aid for the PMMVY is being released to states/UTs on cost sharing basis. The North-Eastern States and Himalayan States have ratio of 90:10 between centre and states. In UTs without legislator, the cost is endured by centre government only & for rest of the India, this ratio is 60:40. Annual reports of MWCD reveals that the highest amount of grant is given to Uttar Pradesh from the date of commencement of the scheme to 31 December 2019. Madhya Pradesh, Andhra Pradesh, Maharashtra, and West Bengal received a major share of total grant given to all states and union territories form centre government. The additional contribution of various state governments i.e. 10 % for North-Eastern States and Himalayan States and 40% for rest of the states makes a huge financial aid dissemination to improve the MMR and IMR.

The number of beneficiaries is surging with time that is an effective indicator of GOI's initiatives to meet the targets of SDG-3. As per report of Ministry of Women & Child Development, as on 9th April, 2019, the number of beneficiaries were 70.64 Lakh. In order to increase the awareness of the scheme and improve overall performance, GOI came up with a 100-day action plan from 31st May, 2019 to 7th September, 2019. The objective was to enrol 12 Lakhs beneficiaries in said period. Several workshops and mass media campaigns were carried out to meet the objective (MWCD report 2019). Information, educational and messaging campaigning to improve public awareness of CMB schemes is being conducted by using various media platforms. As a consequence of such awakening programs of GOI, these numbers are increased to more than 1.36 crore of beneficiaries as on 9th April, 2020. A detailed statistic of number of beneficiaries from 36 states & UTs is embodied in Fig. 3 (MWCD 2019). The number of beneficiaries in Telangana and Orrisa states are less as these states are having parallel state government sponsored CMBs named as KCR kit and MAMTA scheme respectively (Government of Telengana (India) 2017; Government of Odisha (India) 2011). The CMB scheme was implemented in all districts of Haryana from 1.1.2017 on 60:40 ratio cost sharing basis between centre and state government respectively for first living child of the family. The number of beneficiaries in the state are surging with time; as on 09.04.2020, the number of beneficiaries is raised to 3.7 lakh

The routine ANC check-up is vital for a positive pregnancy experience as it diagnose physical normality of mother and fetal. Higher awareness about the importance of ANC is observed among urban and educated women as compared to rural and illiterate women (Tunclap et al 2017). The provision of financial aid in three instalments under PMMVY helps the pregnant women to pursue routine ANC.

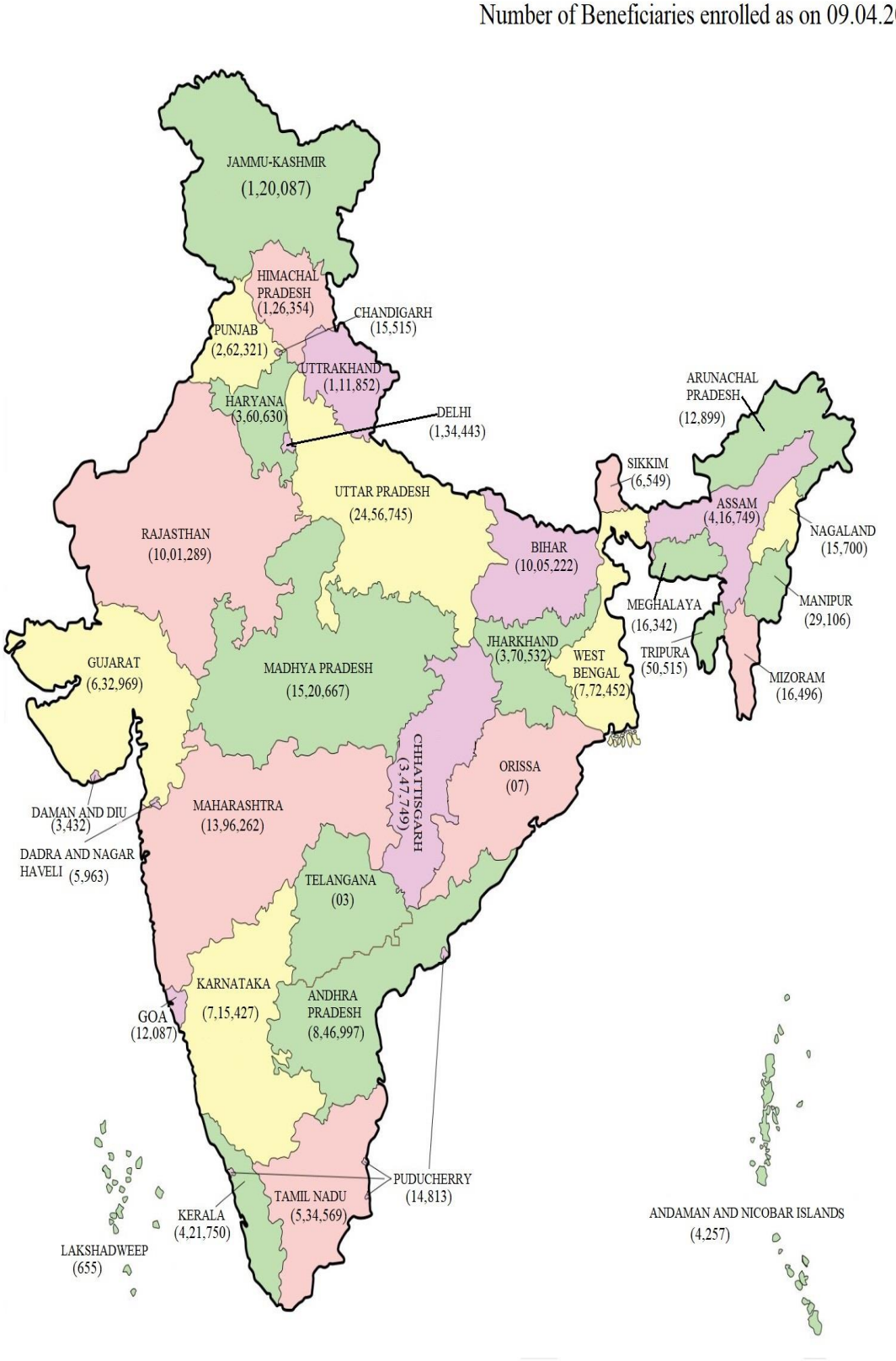

Fig. 3 Number of beneficiaries in different states as on 09.04.2020

The NFHSs and WHO Reports reveal a declining pattern of MMR & IMR in last three decades as illustrated in Fig. 4. Various healthcare programs promoting institutional delivery and the conditional maternity benefit programs have played a vital role in further reducing the MMR & IMR from around 540 to 113 per lakh live births in year 2018 (SRS Bulletin July 2020) and 79 to 32 per thousand live births respectively in year 2020 (SRS Bulletin May 2020). Awareness about maternal and infant healthcare is poor is remote rural areas, & it is an opportunity for GOI as well as private industries to work for well-being of all.

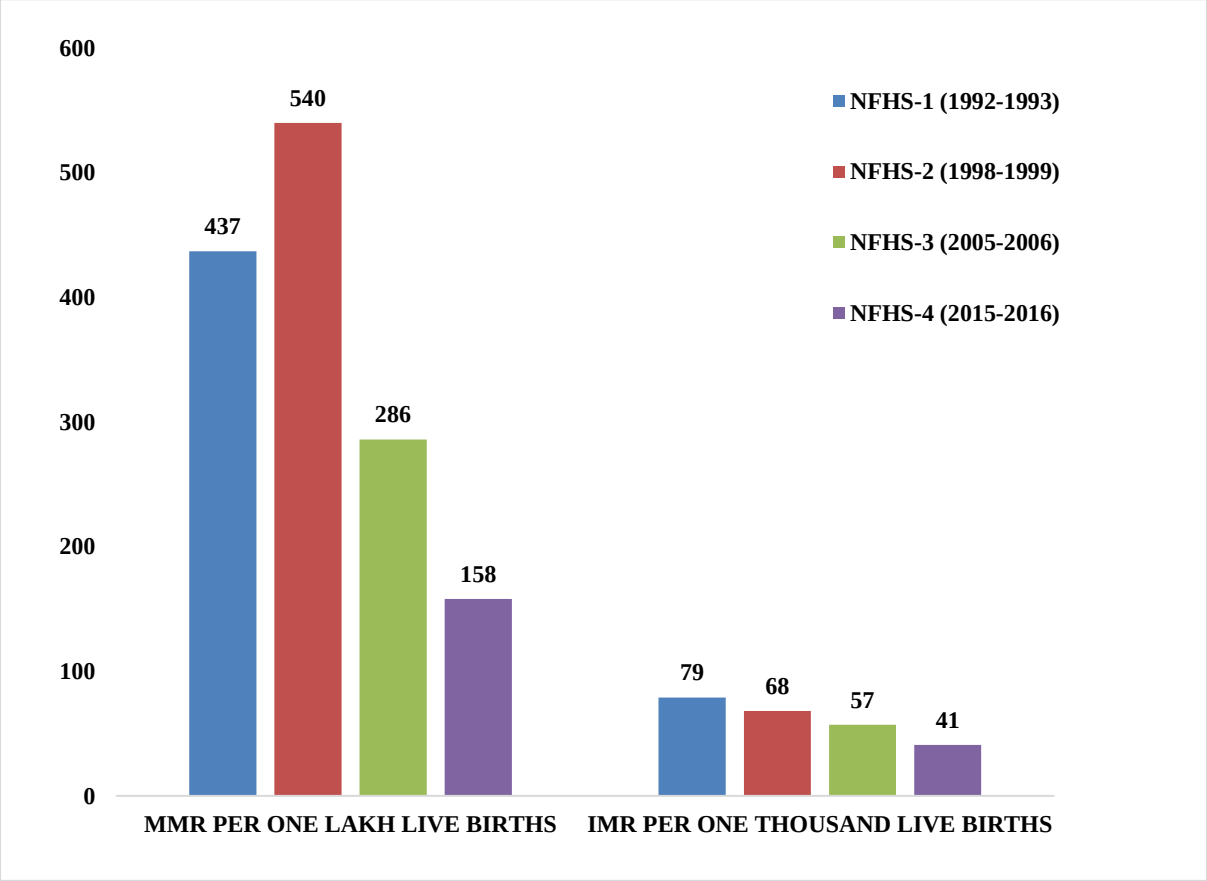

Fig. 4 Variation in MMR & IMR since 1992

Source: NFHS-1, NFHS-2, NFHS-3, NFHS-4, WHO Global Health Report 2000-2017

After reviewing the available literature, it is observed that JSY, being implemented in 2005, have been studied by many researchers in different part of the India. But, PMMVY, being implemented in 2017, is newer and most prolific CMB of the country. It is still a new scheme in the domain of maternal and child healthcare; provides an interesting domain for researchers to explore for betterment of scheme.

2.1 Research gap identified

After scrutinizing the available research articles, GOI reports and various newspaper editorials; following research gaps are identified:

- Since the PMMVY is newly implemented nationwide CMB scheme, not much research has been done for analysing its effect on maternal and child health.
- PMMVY being the first CMB implemented in all districts of Haryana has not been explored for various implementation challenges.
- Implementation challenges among field functionaries of PMMVY are yet to be identified and resolved for better performance of scheme.
- The previous research works have not addressed the role of PMMVY in achieving the sustainable development goal relating to MMR and IMR i.e. SDG-3.
- The people's perception about the CMB scheme is yet to be checked and analysed for finding the important factors which are affecting the implementation process as a whole.
- The awareness level of PMMVY among stakeholders is another key issue of research to find the ways for increasing the its outreach.

So, to fulfil the aforementioned research gaps and for finding the ways to optimize the implementation process of CMB-PMMVY; the present study is undertaken.

3. OBJECTIVES OF THE STUDY

- To assess the level of awareness of PMMVY among potential beneficiaries and role of social marketing initiative to surge the outreach of the program.
- To assess the perception about PMMVY among potential beneficiaries & field functionaries.
- To know the various key factors and challenges in implementation of the PMMVY scheme.
- To check the utilization of money received by PW & LM under the scheme for its intended purpose and role of field functionaries and managing authorities to make the utilization more effective.

4. RESEARCH METHODOLOGY

Research methodology is a well-defined procedure and technique used to find solution for any research problem. A research problem may take several steps or statistical tools to find its

solution. The researcher has to stick to these predefined steps to find a solution. The research methodology answers two main questions.

I. How the data would be collected?
II. How the collected data would be analyzed?

A researcher needs thorough knowledge to define the research methodology for a research problem. A well-defined research methodology plays role of guide for researcher to find a solution and conclude it. So, it plays a vital role in research problem.

4.1 Research Design

A research design is a blueprint for answering the research questions and fulfilling objectives. It is a crucial part of research methodology. Social research needs a well-defined set of steps before data collection. A good research design enables the researcher to collect the evidences to get answer of the initial question as precisely as possible. The present study is exploratory in nature for potential beneficiaries and other stakeholders of PMMVY in Haryana. Exploratory study will be used to explain the awareness, perception, and implementation challenges to stakeholders of PMMVY. To make the study more reliable and accurate self-structured questionnaire will be used to conduct the study.

4.2 Research Universe

The universe of the study is all twenty-two districts of Haryana. The respondents of the study are stakeholders of PMMVY viz. potential beneficiaries, field functionaries. The researcher will get information about perception, awareness, implementation challenges and utilization of money received under the current nationwide implemented CMB scheme i.e. PMMVY. Keeping in view the sample of the study, the Haryana state will be divided into six administrative divisions i.e. Ambala, Faridabad, Gurugram, Hisar, Rohtak, Karnal.

4.3 Sampling Design

The universe of the study is large enough and we cannot study all the units of universe, so sampling units will be selected from the universe. Multistage sampling technique will be used for selecting sampling units. In the first stage, one district will be selected from each division. In the second stage, from the selected district, two blocks will be selected. In third stage, two rural and/or urban entities will be selected randomly from each of the selected blocks. In the last stage we will select 480 potential beneficiaries and 72 field functionaries from the selected

villages using Snowball Sampling Technique. Final sample size will be decided on the basis of results of pilot survey.

4.3 Data Collection

To achieve the objectives, required data will be collected from both the primary and secondary sources. The primary data will be collected through well-designed and objective oriented schedules, it will contain open and closed ended question according the need of the study. The secondary data will be collected from various published sources like research articles, short notes, commentaries, newspapers' editorial and government reports.

4.4 Statistical Tool

The data collected will be analyzed and interpreted by applying need based statistical tools and techniques like percentage, mean, standard deviation, correlation, regression, exploratory factor analysis, confirmatory factor analysis.

5. SCOPE & RELEVANCE OF THE STUDY

The study will be conducted on Haryana in India, with the help of current study we shall know about the PMMVY from beneficiaries' and field functionaries' perspective. Previous researchers' findings laid foundation for a CMB scheme and present study will help in understanding the perception, awareness and implementation challenges of present CMB scheme i.e. PMMVY. We can know about the socio-economic factors that affect the implementation of CMB scheme. The findings of the study will be beneficial for government agencies in adopting more pragmatic approach in implementation of scheme, other health marketing related agencies and lay foundation for further research in the domain of maternal and child healthcare.

6. ORGANIZATION OF THE STUDY

The study is proposed to be organized in following chapters:

Chapter 1: In this chapter, conceptual framework and objectives of the study will be presented.

Chapter 2: In this chapter, literature related to topic will be reviewed to support the present study and identified research gaps will be highlighted.

Chapter 3: This chapter will provide a quick glance on the research process to be followed to achieve the objectives of the study. The chapter will also contain the information on all the statistical tools to be used for analysis and interpretation of data during the course of study.

Chapter 4: This chapter will be dealing with analysis of collected data to achieve the objectives of the study.

Chapter 5: This chapter will summarize the major findings of the study. It will also provide some recommendations based on research findings, which is the goal of this research proposal.

The aforementioned chapters will be followed by bibliography to enable the readers to find the references used. The above scheme of the study is tentative in nature. It may change as for the requirement of the study.

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